

Provider Enrollment: Initially Enrolling a Dentist in the Medicare Program

10/29/2024

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*



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Today's Presenters



- Provider Outreach and Education Consultants
 - Susan Stafford PMP, COA, AMR
 - Laura Brown, CPC



Agenda

- [Overview](#)
- [Dental Specialties](#)
- [Electronic Application: PECOS](#)
 - [Sole Owner Questionnaire](#)
 - [Sole Proprietor Questionnaire](#)
 - [Group Member Questionnaire](#)
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- [Paper Application: CMS-855I](#)
- [Supporting Documentation](#)
- [Process After Submission](#)
- [Check Application Status](#)
- [Contact Information and Resources](#)

Overview

Overview

- Obtain NPI from [NPPES](#)
 - NPI Type 1 for individual physicians or nonphysicians practitioners
 - NPI Type 2 for organization, clinics and/or group practices
- Dental Specialties
- Complete and Submit Medicare Application
 - [PECOS](#) Application
 - Paper Application
 - [CMS-855I](#) – Physicians and Nonphysician Practitioners
 - Reassigning all benefits
 - Sole owner
 - Sole proprietor
 - [CMS-855B](#) – Clinic/Group Practices and other Suppliers
 - Clinic/Group practices with multiple owners
 - One owner but not the practitioner
 - Additional Forms
 - Sole owner, sole proprietor and clinic/group practices
 - [CMS-588](#) –EFT Authorization Agreement
 - [CMS-460](#) – Medicare Participating Physician or Supplier Agreement (optional)

Overview

- Resources
 - [Federal Register Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program](#)
 - [CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 10.2.3.11](#)
 - [How to Determine if the Provider is Active and Get the Provider Enrolled in Medicare Part B](#)
 - [Understanding Participating, Nonparticipating and Opt Out Status](#)
 - [Provider Enrollment: Announcement About Medicare Participation for Calendar Year 2024](#)
 - [Issues with Medicare Beneficiary Submitted Claims – We Need Your Help](#)

Dental Specialties

Dental Specialties

- **Physician Specialty Codes for Dentist**

- 19 Oral Surgery (dentists only)
- 85 Maxillofacial Surgery
- C5 Dentist
- E3 Dental Anesthesiology
- E4 Dental Public Health
- E5 Endodontics
- E6 Oral and Maxillofacial Pathology
- E7 Oral and Maxillofacial Radiology
- E9 Oral Medicine
- F1 Orofacial Pain
- F2 Orthodontics and Dentofacial Orthopedics
- F3 Pediatric Dentistry
- F4 Periodontics
- F5 Prosthodontic



Electronic Application: Provider Enrollment Chain and Ownership System

PECOS Home Page to Login

Medicare Enrollment

for Providers and Suppliers

Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

(*) Red asterisk indicates a required field.

PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

New to PECOS? View our [videos](#) at the bottom of this page.

USER LOGIN

Please use your I&A (Identity & Access Management System) user ID and password to log in.

* User ID

* Password

[LOG IN](#)

[Forgot Password?](#)

[Forgot User ID?](#)

[Manage/Update User Profile](#)

[Who Should I Call? \[PDF, 155KB\]](#) - CMS Provider Enrollment Assistance Guide

BECOME A REGISTERED USER

You may register for a user account if you are: an Individual Practitioner, Authorized or Delegated Official for a Provider or Supplier Organization, or an individual who works on behalf of Providers or Suppliers.

[Register for a user account](#)

Questions? [Learn more about registering for an account](#)

Note: If you are a Medical Provider or Supplier, you must register for an NPI before enrolling with Medicare.

Helpful Links

[Application Status](#) - Self Service Kiosk to view the status of an application submitted within the last 90 days.

[Pay Application Fee](#) - Pay your application fee online.

[View the list of Providers and Suppliers \[PDF, 94KB\]](#) who are required to pay an application fee.

[E-Sign your PECOS application](#) - Access the PECOS E-Signature website using your identifying information, email address, and unique PIN to electronically sign your application.

Provider & Supplier Resources

- [CMS.gov/Providers](#) - Section of the CMS.gov website that is designed to provide Medicare enrollment information for providers, physicians, non-physician practitioners, and other suppliers.
- [Revalidation Notice Sent List](#) - Check to see if you have been sent a notice to revalidate your information on file with Medicare.
- [Enrollment Checklists](#) - Review checklists of information needed to complete an application for various provider and supplier types.
- [Ordering, Certifying, or Prescribing Practitioners List](#) - View the Ordering, Certifying, or Prescribing Practitioners List to verify eligibility to order or certify items or services to Medicare beneficiaries.
- [Medicare Learning Network \(MLN\)](#) - Helpful articles and tutorials about changes in Medicare enrollment.
- [Ordering, Certifying, or Prescribing Information \[PDF, 1.64MB\]](#) - Learn about the Ordering, Certifying, or Prescribing enrollment process.

Enrollment Tutorials

- Initial Enrollment:**
Step-by-step demonstration of an initial enrollment application in PECOS.
[Individual Provider](#) or [Organization/Supplier](#)
- Change of Information:**
Step-by-step demonstration of how to update or change information for an existing enrollment already on file with CMS.
[Individual Provider](#) or [Organization/Supplier](#)
- Revalidation:**
Step-by-step demonstration on how to submit your revalidation application using PECOS.
[Individual Provider](#) or [Organization/Supplier](#)
- Deactivated:**
Example of how to deactivate an existing enrollment record.
[Individual Provider](#)
- Reactivation:**
Step-by-step demonstration of how to re-enroll based on enrollment information that already exists in PECOS.
[Organization/Supplier](#)
- Adding a Practice Location (DMEPOS Only):**
Demonstration of how to add a new practice location for DMEPOS supplier who is already enrolled with CMS.
[DME Supplier](#)

Welcome – My Associates

Welcome

Release Notes

Want to learn what's new in the latest PECOS release? Please review the [Release Notes\[PDF\]](#).

System Notifications

Note: JavaScript must be enabled in your internet browser for PECOS to work properly. If JavaScript is currently disabled in your browser, refer to the Accessibility section in PECOS Help for instructions on enabling JavaScript.

Details

- There are no notifications at this time.

Manage Medicare and Account Information

MY ASSOCIATES 02

- Enroll in Medicare for the first time
- View and update existing Medicare information
- Continue working on saved applications

ACCOUNT MANAGEMENT 02

- Update your user account information, request or remove access to organizations
- Manage access to Medicare enrollments

REVALIDATION NOTIFICATION CENTER 02

- View All Applications requiring revalidation
- Start or continue revalidation application

Manage Signatures

Applications Requiring Signatures

You currently have no pending signatures.

VIEW ALL SIGNATURES 02

Create Initial Enrollment Application

My Associates

Initial Enrollment

Create an application for initial enrollment **ONLY** if you are:

- Enrolling in Medicare for the first time
- Enrolling in a new state, or
- Enrolling with a new specialty

! **IMPORTANT:**

If you are responding to a request for Revalidation, do not create an initial enrollment application. Instead, select a provider from the "Existing Associates" section below then select from the list of existing enrollments.

Please Note: If your organization is currently enrolled in Medicare but you do not see your enrollment, please take the following steps to confirm your access to the enrollment.

- If you are a Staff End User of the organization, please contact the organization's Authorized/Delegated Official to ensure your account has access to PECOS.
- If you are an Authorized/Delegated Official of the organization, please confirm your role with the organization and ensure access to PECOS is active. To verify your account status, select the Account Management button on the Home Page and then choose Update user account information option.

The following checklists will help you gather the information needed to enroll via Internet-based PECOS:

- [Checklist for Sole Proprietor or Solely Owned Organizations \(eg. LLC, PC\) using PECOS](#)
- [Checklist for Individual Physician and Non-Physician Practitioners using PECOS](#)
- [Checklist for Provider or Supplier Organization using PECOS](#)

Select the Create Initial Enrollment Application button **ONLY** if you are enrolling for the first time, or enrolling in a new state or specialty.

[CREATE INITIAL ENROLLMENT APPLICATION >>](#)

Application Questionnaire

Application Questionnaire

(*) Red asterisk indicates a required field.

Applicant Identification

* Which provider is the application being created for?

Individuals

Name: (You) NPI:

Organizations

Name: TIN:

Healthcare Services Rendered

Application Questionnaire

(*) Red asterisk indicates a required field.

Healthcare Services Rendered

* Please select the option that best represents the healthcare service rendered for this application.

- Institutional Provider (e.g., Hospital, Skilled Nursing Facility, Hospice, Home Health Agency)
- Clinics/Group Practices and Certain Other Suppliers (e.g., Ambulance Service Supplier, Clinic, Independent Diagnostic Testing Facility, Sole Owner of a Professional Association (PA), Professional Corporation (PC), or Limited Liability Corporation (LLC))
- Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Medicare Diabetes Prevention Program Supplier (MDPP)
- Individual Physician or Non-Physician Practitioner (including Sole Owner of a Professional Association (PA), Professional Corporation (PC), or Limited Liability Corporation (LLC))
- Eligible Ordering, Certifying, and Prescribing Physicians, and Other Eligible Professionals

Note: Select this option only if any of the following applies to the applicant:

1. The applicant, or any organization employing the applicant, will not send claims to a Medicare contractor for any service furnished by the applicant.
2. The applicant, or any organization employing the applicant, sends claims through a Medicare managed care plan.

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CANCEL

Individual Physician or Non-Physician Practitioner (including Sole Owner of a Professional Association (PA), Professional Corporation (PC), or Limited Liability Corporation (LLC))

Applicant Description

Application Questionnaire (*) Red asterisk indicates a required field.

Applicant Description

Please read through all the descriptions and then choose the one that best matches your situation.

* I am applying as a:

- Sole Owner of a PA, PC or LLC**
 - You are the only owner of a business, set up as a corporation, through which you give healthcare services.
 - Your business is *legally separate* from your personal assets.
- Self-Employed/Sole Proprietor**
 - You give *all* your healthcare services from a facility that you own, lease or rent.
 - You are the only owner of a business that gives healthcare services.
 - You and your business are *legally one and the same*. You are personally responsible for any of the business's financial obligations.
 - You report the business's income and losses on your personal tax return.
- Group Member Only**
 - You give all your healthcare services as an employee of a group practice or clinic.
 - You have an arrangement with your employer to send in Medicare claims and get paid for the services you have given.
- Group Member and is Self-Employed**
 - You give *some* healthcare services as an employee of a group practice or clinic.
 - You have an arrangement with your employer to send in Medicare claims and get paid for the services you have given.
 - You also give *some* healthcare services from a facility that you own, lease or rent.
 - The income you make through self-employment is part of your personal assets.
- Disregarded Entity**
 - You are the only owner of a business, set up as a corporation, through which you give healthcare services.
 - You and your business are considered *legally one and the same*.

PREVIOUS PAGE NEXT PAGE CANCEL

- Sole Owner of a PA, PC or LLC**
 - You are the only owner of a business, set up as a corporation, through which you give healthcare services.
 - Your business is *legally separate* from your personal assets.

- Self-Employed/Sole Proprietor**
 - You give *all* your healthcare services from a facility that you own, lease or rent.
 - You are the only owner of a business that gives healthcare services.
 - You and your business are *legally one and the same*. You are personally responsible for any of the business's financial obligations.
 - You report the business's income and losses on your personal tax return.

- Group Member Only**
 - You give *all* your healthcare services as an employee of a group practice or clinic.
 - You have an arrangement with your employer to send in Medicare claims and get paid for the services you have given.

Sole Owner Questionnaire

Sole Owner Questionnaire

Application Questionnaire

Practitioner as Sole-Owner of an Incorporated Business

This enrollment application is for an individual who has formed a professional corporation (PC), professional association (PA) or a limited liability company (LLC).

- Practitioner is a sole-owner of a business that is legally separate and distinct from the owner.
- The Medicare services provided by the business are by the sole-owner or other practitioners reassigned (as employees or as contractors) to the business.

[PREVIOUS PAGE](#) [NEXT PAGE](#)

[CANCEL](#)

Application Questionnaire

Applicant Identification Information

First Name:

Last Name:

Social Security Number (SSN): XXX-XX-XXXX

Date of Birth: 01/01/XXXX

[PREVIOUS PAGE](#) [NEXT PAGE](#)

[CANCEL](#)

Application Questionnaire

State/Territory Where Healthcare Services Rendered

(*) Red asterisk indicates a required field.

Please select a single state/territory where the applicant renders healthcare services.

* State/Territory

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[CANCEL](#)

Sole Owner Questionnaire

Application Questionnaire

(*) Red asterisk indicates a required field.

Primary Medicare Services Rendered

Note: A separate application is required for each primary healthcare service rendered.

* Please select the primary Medicare Services rendered by the applicant (i.e., individual practitioner who is the sole owner of the PA/PC/LLC).

Part B Physician Specialties

Select Physician Specialty

Part B Non-physician Specialties

Select Non-Physician Specialty

Undefined Type Specification

- Select Physician Specialty
- ADDICTION MEDICINE
 - ADULT CONGENITAL HEART DISEASE (ACHD)
 - ADVANCED HEART FAILURE AND TRANSPLANT CARDIOLOGY
 - ALLERGY/IMMUNOLOGY
 - ANESTHESIOLOGY
 - CARDIAC ELECTROPHYSIOLOGY
 - CARDIAC SURGERY
 - CARDIOVASCULAR DISEASE (CARDIOLOGY)
 - CHIROPRACTIC
 - COLORECTAL SURGERY (PROCTOLOGY)
 - CRITICAL CARE (INTENSIVISTS)
 - DENTAL ANESTHESIOLOGY
 - DENTAL PUBLIC HEALTH
 - DENTIST
 - DERMATOLOGY
 - DIAGNOSTIC RADIOLOGY
 - EMERGENCY MEDICINE
 - ENDOCRINOLOGY
 - ENDODONTICS

Sole Owner Questionnaire

Application Questionnaire (*) Red asterisk indicates a required field.

Primary Medicare Services Rendered

Note: A separate application is required for each primary healthcare service rendered.

* Please select the primary Medicare Services rendered by the applicant (i.e., supplier type of the PA/PC/LLC).

Part B Supplier Services

CLINIC/GROUP PRACTICE

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Application Questionnaire (*) Red asterisk indicates a required field.

IHS Provider

* Is the applicant an Indian Health Service (IHS) facility?

Yes

No

PREVIOUS PAGE NEXT PAGE CANCEL

Application Questionnaire (*) Red asterisk indicates a required field.

Business Identification Information

Please provide the incorporated business' identification information, which is issued by the Internal Revenue Service (IRS).

* Legal Business Name

* Tax Identification Number (TIN)

XX-XXXXXXX

PREVIOUS PAGE NEXT PAGE CANCEL

Sole Owner - Reason for Application

Confirm Reason for Application

Medicare Part B Enrollment

Based on your responses, the following reason for application was identified.

- A Medicare Part B practitioner is enrolling in the Medicare program for the first time as a corporation, professional association, or limited liability company. No reassignment of benefits exists with this application.


The application is for:


Name	Social Security Number (SSN)	Practitioner Specialty	State
[REDACTED]	[REDACTED] XXX-XX-XXXX	DENTIST	CONNECTICUT

Clicking on the 'Start Application' button will create a Medicare application using the above information.
Please note: After you click 'Start Application' a Web Tracking ID will be created. This does not mean that your application has been submitted.

At the conclusion of this process:

- The application is submitted to the appropriate Medicare fee-for-service contractor(s) for processing
- The practitioner must sign a statement certifying the submitted information
- The certification statement, additional required signatures, and required attachments must be electronically signed or mailed to the identified fee-for-service contractor(s)
- The Medicare enrollment is finalized after the fee-for-service contractor processes this application and approves the information
- Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor

[START APPLICATION](#) 

[CANCEL](#) 

Sole Owner – Topic View

Topic View | *Fast Track View* | *Error/Warning Check* **15**

Enrollment ID: [REDACTED]
PacID: [REDACTED]
Web Tracking ID: [REDACTED]
Individual Provider NPI: [REDACTED]

Reason for Application

Practitioner is Enrolling in Medicare for the First Time as a Professional Corporation, Professional Association, or Limited Liability Company

Reports

Select the hyperlink to view the Application being edited:
[View Application being edited](#)

Topics

The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.

You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.

This application is collecting the following topics:

This application is collecting the following topics:

Completed	Topics
—	Personal Identifying Information more information about Personal Identifying Information
—	Supplier Type more information about Supplier Type
✓	PA/PC/LLC Information more information about PA/PC/LLC Information
✓	Practitioner Specialty more information about Practitioner Specialty
—	PAR Status Information more information about PAR Status Information
—	Business Information and "Special Payments" Address more information about Business Information and "Special Payments" Address
—	Vehicle Information more information about Vehicle Information
N/A	Geographic Location more information about Geographic Location
—	Rendering Healthcare Services at a Patient's Home more information about Rendering Healthcare Services at a Patient's Home
—	Mailing Address more information about Mailing Address
—	License, Certification, and DEA Information more information about License and Certification Information
—	Final Adverse Legal Actions more information about Final Adverse Legal Actions
—	Individual Control more information about Individual Control
—	Patient Records Storage Location more information about Patient Records Storage Location
—	Billing Agency/Agent more information about Billing Agency/Agent
✓	Contact Person more information about Contact Person
—	Electronic Funds Transfer more information about Electronic Funds Transfer
—	Required and/or Supporting Documentation more information about Required and/or Supporting Documentation

Note:

- Once you have completed all the topics and no errors are present, the 'Begin Submission' button will be enabled. You may review errors at any time by clicking the 'Error Check' tab. Clicking 'Begin Submission' will initiate the Submission Process.

BEGIN SUBMISSION | **NEXT PAGE**

Sole Proprietor Questionnaire

Sole Proprietor Questionnaire

Application Questionnaire

Applicant Identification Information

First Name:

Last Name:

Social Security Number (SSN): XXX-XX-XXXX

Date of Birth: 01/01/XXXX

Application Questionnaire

(*) Red asterisk indicates a required field.

State/Territory Where Healthcare Services Rendered

Please select a single state/territory where the applicant renders healthcare services.

* State/Territory

Sole Owner Questionnaire

Application Questionnaire

(*) Red asterisk indicates a required field.

Primary Medicare Services Rendered

Note: A separate application is required for each primary healthcare service rendered.

* Please select the primary Medicare Services rendered by the applicant (i.e., individual practitioner who is the sole owner of the PA/PC/LLC).

Part B Physician Specialties

Select Physician Specialty

Part B Non-physician Specialties

Select Non-Physician Specialty

Undefined Type Specification

- Select Physician Specialty
- ADDICTION MEDICINE
 - ADULT CONGENITAL HEART DISEASE (ACHD)
 - ADVANCED HEART FAILURE AND TRANSPLANT CARDIOLOGY
 - ALLERGY/IMMUNOLOGY
 - ANESTHESIOLOGY
 - CARDIAC ELECTROPHYSIOLOGY
 - CARDIAC SURGERY
 - CARDIOVASCULAR DISEASE (CARDIOLOGY)
 - CHIROPRACTIC
 - COLORECTAL SURGERY (PROCTOLOGY)
 - CRITICAL CARE (INTENSIVISTS)
 - DENTAL ANESTHESIOLOGY
 - DENTAL PUBLIC HEALTH
 - DENTIST
 - DERMATOLOGY
 - DIAGNOSTIC RADIOLOGY
 - EMERGENCY MEDICINE
 - ENDOCRINOLOGY
 - ENDODONTICS

Sole Proprietor Questionnaire

Application Questionnaire (*) Red asterisk indicates a required field.

Identification Numbers

* Does the applicant want Medicare payments reported under the applicant's EIN instead of the applicant's SSN? (to qualify for this payment arrangement, the applicant must be a sole proprietor and cannot reassign all Medicare payments)

Yes

No

* Employer Identification Number (EIN)

XX-XXXXXXX

Ownership Information

* Effective Date of Ownership

MM/DD/YYYY

* Telephone x Extension

x

No Format Required

Application Questionnaire (*) Red asterisk indicates a required field.

Reassignment of Benefits

* Is the applicant employed by a business or individual that will receive the practitioner's Medicare claims payments?

Yes

No

Sole Proprietor - Reason for Application

Confirm Reason for Application

Medicare Part B Enrollment

Based on your responses, the following reason for application was identified.

- A Medicare Part B practitioner is enrolling in the Medicare program for the first time using their social security number (SSN). No reassignment of benefits exists with this application.

The application is for:

Name	Social Security Number (SSN)	Practitioner Specialty	State
	XXX-XX-XXXX	DENTIST	CONNECTICUT

Clicking on the 'Start Application' button will create a Medicare application using the above information.
Please note: After you click 'Start Application' a Web Tracking ID will be created. This does not mean that your application has been submitted.

At the conclusion of this process:

- The application is submitted to the appropriate Medicare fee-for-service contractor(s) for processing
- The practitioner must sign a statement certifying the submitted information
- The certification statement, additional required signatures, and required attachments must be electronically signed or mailed to the identified fee-for-service contractor(s)
- The Medicare enrollment is finalized after the fee-for-service contractor processes this application and approves the information
- Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor

START APPLICATION

CANCEL

• A Medicare Part B practitioner is enrolling in the Medicare program for the first time using their social security number (SSN). No reassignment of benefits exists with this application.

• A Medicare Part B practitioner is enrolling in the Medicare program for the first time using their social security number (SSN). The Medicare Part B practitioner will be billing using 99-9999999 (EIN). No reassignment of benefits exists with this application.

Sole Proprietor – Topic View

Topic View | **Fast Track View** | **Error/Warning Check 15**

Enrollment ID:
PacID:
Web Tracking ID:
Individual Provider NPI:

Reason for Application

Practitioner Is Enrolling In Medicare for the First Time

Reports

Select the hyperlink to view the Application being edited:
[View Application being edited](#)

Topics

The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.

You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.

This application is collecting the following topics:

Topics

The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.

You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.

This application is collecting the following topics:

Completed	Topics
<input type="checkbox"/>	Personal Identifying Information <small>more information about Personal Identifying Information</small>
<input checked="" type="checkbox"/>	Practitioner Specialty <small>more information about Practitioner Specialty</small>
<input type="checkbox"/>	PAR Status Information <small>more information about PAR Status Information</small>
<input type="checkbox"/>	Business Information and "Special Payments" Address <small>more information about Business Information and "Special Payments" Address</small>
<input type="checkbox"/>	Rendering Healthcare Services at a Patient's Home <small>more information about Rendering Healthcare Services at a Patient's Home</small>
<input type="checkbox"/>	Mailing Address <small>more information about Mailing Address</small>
<input type="checkbox"/>	License, Certification, and DEA Information <small>more information about License and Certification Information</small>
<input type="checkbox"/>	Final Adverse Legal Actions <small>more information about Final Adverse Legal Actions</small>
<input type="checkbox"/>	Organization Control <small>more information about Organization Control</small>
<input type="checkbox"/>	Individual Control <small>more information about Individual Control</small>
<input type="checkbox"/>	Patient Records Storage Location <small>more information about Patient Records Storage Location</small>
<input type="checkbox"/>	Billing Agency/Agent <small>more information about Billing Agency/Agent</small>
<input checked="" type="checkbox"/>	Contact Person <small>more information about Contact Person</small>
<input type="checkbox"/>	Electronic Funds Transfer <small>more information about Electronic Funds Transfer</small>
<input type="checkbox"/>	Required and/or Supporting Documentation <small>more information about Required and/or Supporting Documentation</small>

Note:

- Once you have completed all the topics and no errors are present, the 'Begin Submission' button will be enabled. You may review errors at any time by clicking the 'Error Check' tab. Clicking 'Begin Submission' will initiate the Submission Process.

BEGIN SUBMISSION

Group Member Questionnaire

Group Member Questionnaire

Application Questionnaire

Applicant Identification Information

First Name:

Last Name:

Social Security Number (SSN): XXX-XX-XXXX

Date of Birth: 01/01/XXXX

Application Questionnaire

(*) Red asterisk indicates a required field.

State/Territory Where Healthcare Services Rendered

Please select a single state/territory where the applicant renders healthcare services.

* State/Territory

Sole Owner Questionnaire

Application Questionnaire

(*) Red asterisk indicates a required field.

Primary Medicare Services Rendered

Note: A separate application is required for each primary healthcare service rendered.

* Please select the primary Medicare Services rendered by the applicant (i.e., individual practitioner who is the sole owner of the PA/PC/LLC).

Part B Physician Specialties

Select Physician Specialty

Part B Non-physician Specialties

Select Non-Physician Specialty

Undefined Type Specification

PREVIOUS PAGE NEXT PAGE

CANCEL

- Select Physician Specialty
- ADDICTION MEDICINE
 - ADULT CONGENITAL HEART DISEASE (ACHD)
 - ADVANCED HEART FAILURE AND TRANSPLANT CARDIOLOGY
 - ALLERGY/IMMUNOLOGY
 - ANESTHESIOLOGY
 - CARDIAC ELECTROPHYSIOLOGY
 - CARDIAC SURGERY
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 - DENTAL ANESTHESIOLOGY
 - DENTAL PUBLIC HEALTH
 - DENTIST
 - DERMATOLOGY
 - DIAGNOSTIC RADIOLOGY
 - EMERGENCY MEDICINE
 - ENDOCRINOLOGY
 - ENDODONTICS

Group Member Questionnaire

Application Questionnaire

(*) Red asterisk indicates a required field.

Entity Receiving Benefits Enrollment Status

To avoid delays in processing this application, please ensure an enrollment application for the Entity Receiving Benefits has been submitted or will be submitted. The Entity Receiving Benefits must also be enrolled in the Medicare program.

* Would you like to continue?

Yes

No

[< PREVIOUS PAGE](#) [NEXT PAGE >](#)

[<< CANCEL](#)

Group Member - Reason for Application

Confirm Reason for Application

Medicare Part B Enrollment

Based on your responses, the following reason for application was identified.

- A Medicare Part B practitioner is enrolling in the Medicare program for the first time using their social security number (SSN). A reassignment of all benefits exists with this application.

The application is for:

Name	Social Security Number (SSN)	Practitioner Specialty	State
	XXX-XX-XXXX	DENTIST	CONNECTICUT

Clicking on the 'Start Application' button will create a Medicare application using the above information.
Please note: After you click 'Start Application' a Web Tracking ID will be created. This does not mean that your application has been submitted.

At the conclusion of this process:

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- The practitioner must sign a statement certifying the submitted information
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- The Medicare enrollment is finalized after the fee-for-service contractor processes this application and approves the information
- Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor

[START APPLICATION](#)

[CANCEL](#)

Group Member – Topic View

Topic View | [Fast Track View](#) | [Error/Warning Check](#) **8**

Enrollment ID:
PacID: /
Web Tracking ID:
Individual Provider NPI:

Reason for Application

Practitioner Is Enrolling In Medicare for the First Time

Reports

Select the hyperlink to view the Application being edited:
[View Application being edited](#)

Topics

The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.

You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.

This application is collecting the following topics:

Completed	Topics
—	Personal Identifying Information <small>+ more information about Personal Identifying Information</small>
✓	Practitioner Specialty <small>+ more information about Practitioner Specialty</small>
—	Reassignment <small>+ more information about Reassignment</small>
—	Mailing Address <small>+ more information about Mailing Address</small>
—	License, Certification, and DEA Information <small>+ more information about License and Certification Information</small>
—	Final Adverse Legal Actions <small>+ more information about Final Adverse Legal Actions</small>
—	Organization Control <small>+ more information about Organization Control</small>
✓	Contact Person <small>+ more information about Contact Person</small>
—	Required and/or Supporting Documentation <small>+ more information about Required and/or Supporting Documentation</small>

Note:

- Once you have completed all the topics and no errors are present, the 'Begin Submission' button will be enabled. You may review errors at any time by clicking the 'Error Check' tab. Clicking 'Begin Submission' will initiate the Submission Process.

[BEGIN SUBMISSION](#) **»**

[NEXT PAGE](#) **»**

Errors/Warning Check

Error/Warning Check

Topic View Fast Track View **Error/Warning Check 2**

Enrollment Submission

Note: Your application is ready for submission with warning messages. Please review the warning messages and select the Begin Submission button.

BEGIN SUBMISSION

Enrollment ID:
PaclD:
Web Tracking ID:
Individual Provider NPI:

Errors for this Enrollment

No Errors were found for this enrollment application.

Warnings for this Enrollment

Warnings were found for this enrollment application. Please review the warnings listed below and verify that the information entered is correct.

Verification of this information is optional; the submission process may continue without verification of this information.

Topic	Warning
Individual Control	Each enrollment is recommended to have at least one individual designated as the managing employee.
Reassignment	Reassignment of Benefits exist that are missing a primary and/or secondary practice location. It is recommended that a primary and secondary practice location be specified, but are not required.

Manage Signatures

Select Signatories

(*) Red asterisk indicates a required field.

Signatory for Organization Enrollment

The selected Signer will be responsible the Electronic Funds Transfer Agreement and Certification Statement for the Organization Enrollment.

* Authorized Signer
Please select authorized signer ▼

[NEXT PAGE](#)

[RETURN TO MY ENROLLMENTS](#)

Manage Signatures

Home > My Associates > My Enrollments > Reassignment > Submission Process

Manage Signatures

(*) Red asterisk indicates a required field.

Name: _____
Web Tracking ID: _____ TIN: XX-XXXXXXX

NEW! PECOS now allows users to upload signed documents. Please upload your certification statement(s), authorization statement(s), and CMS-588 forms on this page, or after submission, by navigating to the My Enrollments page and selecting the Manage Signatures option.

Note: Users will no longer be able to mail in signature documents. Please select either Electronic or Upload.

NEW! - Any Authorized or Delegated Officials with an ITIN will not be able to submit electronic signatures. Authorized or Delegated Officials with an ITIN entered on this application **must now upload their signature documents**.

Please select a signature method for each signer:

Name: Donald Duck
SSN: XXX-XX-XXXX
* Signature Method for Donald Duck:

Role: AUTHORIZED OFFICIAL
Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)

Electronic
 Upload

Name: [You]
SSN: XXX-XX-XXXX
* Signature Method for

Role: PRACTITIONER
Document: CERTIFICATION STATEMENT FOR INDIVIDUAL PRACTITIONERS

E-Sign (Sign Now)
 Upload

Role: PRACTITIONER
Document: AUTHORIZATION STATEMENT FOR INDIVIDUAL PRACTITIONERS (855R)

[PREVIOUS PAGE](#) [NEXT PAGE](#)

[RETURN TO MY ENROLLMENTS](#)

Manage Signatures

Name: Donald Duck
SSN: XXX-XX-XXXX
*** Signature Method for Donald Duck:**

Electronic
 Upload

Role: PRACTITIONER
Document: AUTHORIZATION STATEMENT FOR INDIVIDUAL PRACTITIONERS (855R)

Role: PRACTITIONER
Document: CERTIFICATION STATEMENT FOR INDIVIDUAL PRACTITIONERS

*** Email Address**

*** Confirm Email Address**

Name: Donald Duck
SSN: XXX-XX-XXXX
*** Signature Method for Donald Duck:**

Electronic
 Upload

Role: PRACTITIONER
Document: CERTIFICATION STATEMENT FOR INDIVIDUAL PRACTITIONERS

Role: PRACTITIONER
Document: AUTHORIZATION STATEMENT FOR INDIVIDUAL PRACTITIONERS (855R)

Note: You may upload a signature document now, prior to application submission, or after the submission of this application. To upload a signature document after submission, or to change the signature method, navigate to the My Enrollments page, find this application, and select the Manage Signatures option.

The following documents can be used to upload a signature:

- Signature page from the corresponding Medicare provider/supplier enrollment application form available on the CMS website.
- Signature page from the Required/Supporting Documentation topic, or from the My Enrollments Page select this application then select View > View Printable Certification

To upload a signature document now, browse for the file then select the Upload button.

Document: CERTIFICATION STATEMENT FOR INDIVIDUAL PRACTITIONERS ⓘ

No file chosen

Document: AUTHORIZATION STATEMENT FOR ORGANIZATIONS (855R)

No file chosen

Complete Submission

Submission Page

(*) Red asterisk indicates a required field.

Medicare Contractor

The Medicare Contractor(s) listed here would be responsible for processing your electronic and printed application materials. If more than one contractor is listed, you must mail copies of print documents to each contractor listed. **You must mail all required print documents within 15 days of submitting the electronic part of your application.**

Medicare Contractor: NATIONAL GOVERNMENT SERVICES, INC.

NATIONAL GOVERNMENT SERVICES, INC.
PO BOX
INDIANAPOLIS, IN

Reason(s) for submission:

- A Medicare Part B practitioner is enrolling in the Medicare program for the first time to bill for Part B services. A reassignment of benefits may exist.

Required and/or Supporting Documentation Information

▼ Expand to display the Required and/or Supporting Documentation. Checklist for this Medicare enrollment application submission.


Documentation Requiring Signatures: MUST E-SIGN or UPLOAD	View and Print Documentation	Comments
Authorized Official Certification Statement for Clinics and Group Practices [PDF]	View and Print [PDF]	
Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.		
Certification Statement for Individual Practitioners [PDF]	View and Print [PDF]	
Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.		
Form CMS-855R, Authorization Statement for Reassignment of Medicare Benefits	View and Print [PDF]	
Note: Please do not mail a signed Certification Statement. Signature documents must be either e-signed or uploaded.		

Note: Documents in PDF format require the [Adobe Acrobat Reader](#). If you experience problems with PDF documents, please [download the latest version of the Reader](#).

[PREVIOUS PAGE](#) [COMPLETE SUBMISSION](#) 

[CANCEL](#)

Submission Confirmation

 **IMPORTANT!**

Your enrollment application with any uploaded documentation has been submitted to your fee-for-service contractor.

Required and/or supporting documentation not e-signed or uploaded must be mailed in to the fee-for-service contractor.

You indicated the following documentation will be provided by mail/paper:

- Form CMS-460, Medicare Participating Physician or Supplier Agreement
- Copy of IRS Form CP 575 or other official IRS communication confirming Tax Identification Number and Legal Business Name

Your application may be delayed or not processed if any required/supporting documentation is missing.

My Application Progress  100%

Submission Confirmation - Print Your Receipt

Submission Complete

You have successfully submitted your application! 

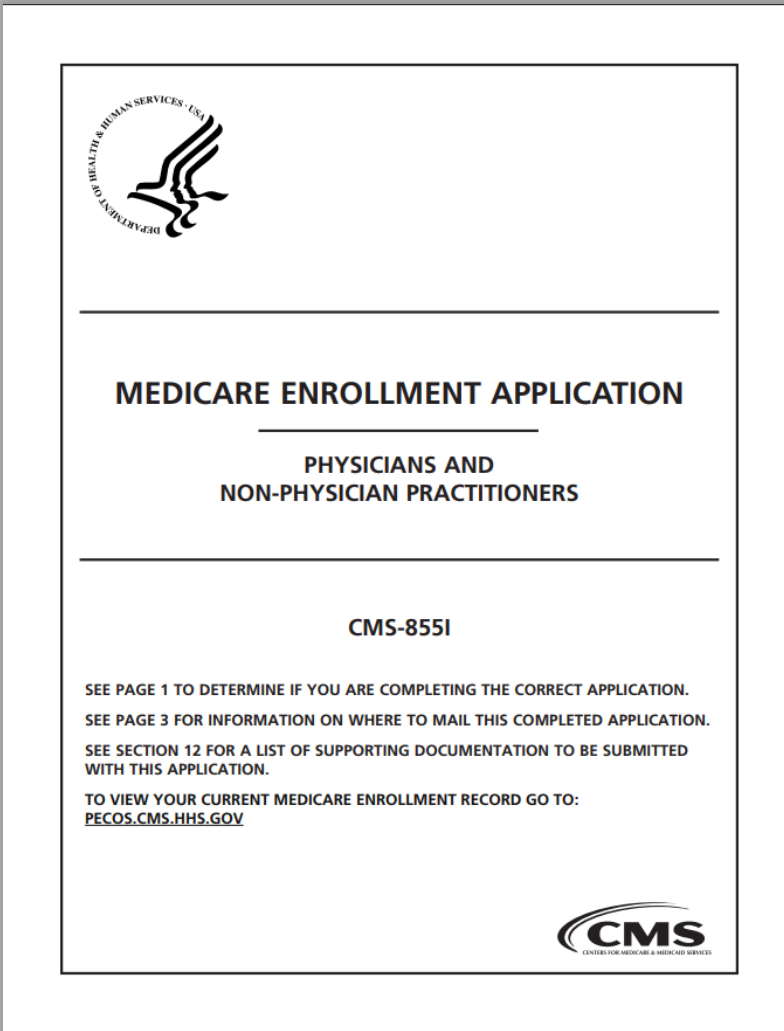
Remember to:

- Make sure all required and supporting documents that require a signature are signed.
- Mail all required and supporting documents that has not been uploaded to your Medicare Contractor within 15 days of submitting the electronic part of your application. Your application is not complete until the Medicare Contractor(s) receives the signed required documentation of your application in the mail.
- Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor.
- Your application may be delayed or not processed if any required/supporting documentation is missing.
- If you are submitting an application with Electronic Funds Transfer (EFT) information, please include confirmation of account information on bank letterhead or a voided check.
- Print this page for your records. **Note:** You can print and/or save copies of the application and required documents for your records by visiting the "My Enrollments" page.
- You will receive e-mails about your application status. Make sure to add "customerservice-donotreply@cms.hhs.gov" to your safe sender list.


You have successfully submitted your application!

Paper Application: CMS-855I

CMS-855I



The image shows the cover page of the CMS-855I Medicare Enrollment Application. At the top left is the Department of Health & Human Services logo. The title "MEDICARE ENROLLMENT APPLICATION" is centered, followed by "PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS". Below that is the form number "CMS-855I". A block of text provides instructions: "SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION. SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION. SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION. TO VIEW YOUR CURRENT MEDICARE ENROLLMENT RECORD GO TO: [PECOS.CMS.HHS.GOV](https://pecos.cms.hhs.gov)". The CMS logo is at the bottom right.




MEDICARE ENROLLMENT APPLICATION

**PHYSICIANS AND
NON-PHYSICIAN PRACTITIONERS**

CMS-855I

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.
SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.
SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED
WITH THIS APPLICATION.

TO VIEW YOUR CURRENT MEDICARE ENROLLMENT RECORD GO TO:
[PECOS.CMS.HHS.GOV](https://pecos.cms.hhs.gov)



Section 1: Basic Information

A. Reason for Submitting this Application

- Mark and complete entire application for
 - New enrollee
 - Currently enrolled to order/refer only and want to enroll to bill Medicare
 - Enrolling with another MAC
 - Revalidating
 - Reactivating
- Mark and complete specified section if
 - Reporting a change; or
 - Voluntarily terminating

SECTION 1: BASIC INFORMATION	
A. REASON FOR SUBMITTING THIS APPLICATION	
Check one box and complete the sections of this application as indicated.	
<input type="checkbox"/> You are a new enrollee in Medicare	Complete all applicable sections
<input type="checkbox"/> You are currently enrolled in Medicare to order and certify and want to enroll as an Individual Practitioner	Complete all applicable sections
<input type="checkbox"/> You are enrolling with another Medicare Administrative Contractor (MAC)	Complete all applicable sections
<input type="checkbox"/> You are revalidating your Medicare enrollment	Complete all applicable sections
<input type="checkbox"/> You are reactivating your Medicare enrollment	Complete all applicable sections
<input type="checkbox"/> You are reporting a change to your Medicare enrollment information (includes establishing or terminating a reassignment)	Go to section 1B below
<input type="checkbox"/> You are voluntarily terminating your Medicare enrollment Effective date of termination (mm/dd/yyyy): _____	Sections 1A, 2A, 13 (optional), and 15
B. WHAT INFORMATION IS CHANGING?	
Check all that apply and complete the required sections.	
Please note: When reporting ANY information, sections 1, 2A, 3 and 15 MUST always be completed in addition to the information that is changing within the required section.	
<input type="checkbox"/> Personal Identifying Information	1, 2A, 3, 12, 13 (optional) and 15
<input type="checkbox"/> Final Adverse Legal Actions	1, 2A, 3, 12, 13 (optional) and 15
<input type="checkbox"/> Medical Specialty Information	1, 2A, 2G or 2H, 3, 4, 12, 13 (optional), and 15
<input type="checkbox"/> Practitioner Specific Information	1, 2A, 2B-2F, 2I-2K (as applicable), 3, 12, 13 (optional), and 15
<input type="checkbox"/> Reassignment of Benefits Information	1, 2A, 4F, 12, 13 (optional) and 15
<input type="checkbox"/> Private Practice Business Information	1, 2A, 3, 4A, 12, 13 (optional) and 15
<input type="checkbox"/> Managing Employee Information	1, 2A, 3, 6, 12, 13 (optional), and 15
<input type="checkbox"/> Address Information	1, 2A, 3, 12, 13 (optional) and 15 AND sections 2D, 2E, 4B, 4C, and/or 4D as applicable for the address that is being changed
<input type="checkbox"/> Correspondence Mailing Address	
<input type="checkbox"/> Medical Record Correspondence Mailing Address	
<input type="checkbox"/> Remittance Notices/Special Payment Mailing Address	
<input type="checkbox"/> Medicare Beneficiary Medical Records Storage Address	
<input type="checkbox"/> Practice Location Address	
<input type="checkbox"/> Billing Agency Information	1, 2A, 3, 6, 8, 13 (optional) and 15
<input type="checkbox"/> Any other information not specified above	1, 2A, 3, 13 (optional) and 15 and the applicable section or sub-section that is changing

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Section 2: Personal Identifying Information

G. Physician Specialty

- Select a primary specialty (designated with a “P”)
 - you may select multiple secondary specialties (designated with “S”)
- Must meet all federal and state requirements for specialty checked

SECTION 2: PERSONAL IDENTIFYING INFORMATION (Continued)

F. RESIDENT INFORMATION (Continued)

3. Do you also render services at other facilities or practice locations? Yes No
 If yes, you must report these practice locations in section 4B and/or section 4F.

4. Are the services that you render in any of the practice locations you will be reporting in section 4B and/or section 4F part of your requirements for graduation from a residency program? Yes No
 If yes, has the teaching hospital/facility reported in section 2F1 above agreed to incur all or substantially all of the costs of your training in the non-hospital/facility location? Yes No

G. PHYSICIAN SPECIALTY
 Designate your primary specialty and all secondary specialty(s) below using:
P=Primary S=Secondary

You can only select one primary specialty. If you have multiple primary specialties, you must complete and submit a separate CMS-8551 application for each primary specialty. You may select multiple secondary specialties. A physician must meet all federal and state requirements for the type of specialty(s) checked.

<input type="checkbox"/> Addiction Medicine	<input type="checkbox"/> Hematology	<input type="checkbox"/> Orthopedic Surgery
<input type="checkbox"/> Adult Congenital Heart Disease	<input type="checkbox"/> Hematology/Oncology	<input type="checkbox"/> Osteopathic Manipulative Medicine
<input type="checkbox"/> Advanced Heart Failure and Transplant Cardiology	<input type="checkbox"/> Hematopoietic Cell Transplantation and Cellular Therapy	<input type="checkbox"/> Otolaryngology
<input type="checkbox"/> Allergy/Immunology	<input type="checkbox"/> Hospice/Palliative Care	<input type="checkbox"/> Pain Management
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Hospitalist	<input type="checkbox"/> Pathology
<input type="checkbox"/> Cardiac Electrophysiology	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Pediatric Medicine
<input type="checkbox"/> Cardiac Surgery	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Cardiovascular Disease (Cardiology)	<input type="checkbox"/> Interventional Cardiology	<input type="checkbox"/> Physical Medicine and Rehabilitation
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Interventional Pain Management	<input type="checkbox"/> Plastic and Reconstructive Surgery
<input type="checkbox"/> Colorectal Surgery (Proctology)	<input type="checkbox"/> Interventional Radiology	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Critical Care (Intensivists)	<input type="checkbox"/> Maxillofacial Surgery	<input type="checkbox"/> Preventive Medicine
<input type="checkbox"/> Dentist	<input type="checkbox"/> Medical Genetics and Genomics	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Medical Oncology	<input type="checkbox"/> Pulmonary Disease
<input type="checkbox"/> Diagnostic Radiology	<input type="checkbox"/> Medical Toxicology	<input type="checkbox"/> Radiation Oncology
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Micrographic Dermatologic Surgery	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Sleep Medicine
<input type="checkbox"/> Family Medicine	<input type="checkbox"/> Neurology	<input type="checkbox"/> Sports Medicine
<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Neuropsychiatry	<input type="checkbox"/> Surgical Oncology
<input type="checkbox"/> General Practice	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Thoracic Surgery
<input type="checkbox"/> General Surgery	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Undersea and Hyperbaric Medicine
<input type="checkbox"/> Geriatric Medicine	<input type="checkbox"/> Obstetrics/Gynecology	<input type="checkbox"/> Urology
<input type="checkbox"/> Geriatric Psychiatry	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Vascular Surgery
<input type="checkbox"/> Gynecological Oncology	<input type="checkbox"/> Optometry	<input type="checkbox"/> Undefined Physician Specialty (Specify): _____
<input type="checkbox"/> Hand Surgery	<input type="checkbox"/> Oral Surgery	

1. Does the physician identified in section 2A provide acupuncture services and meet all state laws and requirements regarding such services? Yes No

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Section 4: Business Information

- Check applicable box for additional instructions
 - Individual reassigning all benefits, 4F only
 - Sole Owner and also reassigning benefits, 4A – 4F
 - Sole Proprietor in private practice, not reassigning benefits, 4A – 4E
- A. Private Practice Business Information
 - Identify business structure
 - Sole Owner: PC, PA or LLC complete sections 4A1 and 4A2
 - Sole Proprietor complete section 4A3
 1. Corporations, Associations and Limited Liability Company (LLC)
 - Indicate legal business name and TIN as it appears on the IRS document
 2. Final Adverse Legal Action History
 - Indicate any final adverse legal action history on the entity identified in this section

SECTION 4: BUSINESS INFORMATION

If you do **NOT** have a private practice but you reassign **ALL** of your benefits to an organization/group or individual, check this box and only complete section 4F.

If you **DO** have a private practice and you also reassign **ANY** of your benefits to an organization/group or individual, check this box and complete sections 4A – 4E.

If you **DO** have a private practice and **ONLY** render services in your own private practice, check this box and complete sections 4A – 4E.

A. PRIVATE PRACTICE BUSINESS INFORMATION Private Practice

Business Structure Information
Identify how your business is registered with the IRS:
 Proprietary Non-Profit (Submit IRS Form 501(c)(3)) Disregarded Entity (Submit IRS Form 8832)

For the purposes of section 4A, if you are a:

- Professional Corporation, complete 4A1 and 4A2
- Professional Association, complete 4A1 and 4A2
- Limited Liability Company (LLC), including a single member LLC, complete 4A1 and 4A2
- Sole proprietor/Sole proprietorship, complete 4A3

1. Corporations, Associations and Limited Liability Company (LLC)
If your private practice is established as a professional corporation, professional association or limited liability company, including single member LLCs and you are the sole owner and will bill Medicare through this business entity, complete this section with information about your business entity.
NOTE: If you are filling out section 4A, you do not need to complete section 4F to reassign your benefits as a practitioner to your business entity.
NOTE: The LBN and TIN you furnish in section 4A must be the same LBN and TIN you used to obtain your NPI.

Legal Business Name as Reported to the Internal Revenue Service

Tax Identification Number	Medicare Identification Number (PTAN) (if issued)	NPI (Type 2 – Organization)

2. Final Adverse Legal Action History
Complete this section for your business as reported in section 4A1 above. If you need additional information regarding what to report, please refer to section 3 of this application.
NOTE: This section not required for Sole Proprietor/Sole Proprietorships.

a. Has your business, under any current or former name or business identity, had a final adverse legal action listed in section 3 of this application imposed against it?
 YES – continue below
 NO – skip to section 4

b. If yes, report each final adverse legal action, when it occurred, and the federal or state agency or the court/administrative body that imposed the action.

NOTE: To satisfy the reporting requirement, section 4A2 must be filled out in its entirety, and all applicable attachments must be included.

FINAL ADVERSE LEGAL ACTION	DATE	ACTION TAKEN BY

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Section 4: Business Information

F. Individual/Organization/Group Receiving the Reassigned Benefits

1. Individual Practitioner Receiving Reassigned Benefits Identification

- Legal Name
- SSN or EIN

2. Organization/Group Receiving Reassigned Benefits Identification

- Legal Business Name
- TIN

- **Note:** All reassignment actions should be reported via the CMS-855I

Reassignment

SECTION 4: BUSINESS INFORMATION (Continued)

F. INDIVIDUAL/ORGANIZATION/GROUP RECEIVING THE REASSIGNED BENEFITS
NOTE: All reassignment actions should now be reported via the CMS-855I. The CMS-855R (Reassignment of Medicare Benefits) form has been discontinued.

Complete this section if you are:

1. An individual practitioner reassigning your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries, terminating a currently established reassignment of benefits, making a change in reassignment of Medicare benefit information; or
2. An organization/group accepting a new reassignment of Medicare benefits from the individual practitioner identified in section 2A, terminating a currently established reassignment of benefits from the individual practitioner identified in section 2A, or making a change in reassignment of Medicare benefit information, between the organization/group and the individual practitioner identified in section 2A.

The individual or delegated/authorized official, by his/her signature, agrees to notify the Medicare Administrative Contractor (MAC) of any future changes to this reassignment in accordance with 42 C.F.R. section 424.516(d)(2).

Both the individual practitioner and the eligible organization/group must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible organization/group and the CMS-855I for the individual practitioner) in the Medicare program before the reassignment can take effect.

If you reassign benefits to more than one organization/group, copy and complete this page as necessary.
NOTE: Revalidation applications must list all active reassignments.

1. Individual Practitioner Receiving Reassigned Benefits Identification

Provide the information below for the individual to whom benefits are being reassigned, or a reassignment is being terminated. If the individual's initial enrollment application is being submitted concurrently with this reassignment, write "pending" in the Medicare identification number block. The individual's name as reported to the Social Security Administration must be the same as reported on the individual's CMS-855I when the individual enrolled. If the individual is a sole proprietor with an Employee Identification Number (EIN), check the appropriate box and report the EIN.

Change Add Terminate **Effective Date (mm/dd/yyyy):** _____

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
_____	_____	_____	_____

<input type="checkbox"/> Social Security Number (SSN) (List number below if applicable)	<input type="checkbox"/> Employer Identification Number (EIN) (List number below if applicable)
_____	_____

Medicare Identification Number (PTAN) (if issued)	National Provider Identifier (NPI)
_____	_____

2. Organization/Group Receiving Reassigned Benefits Identification

Provide the information below for the organization/group to which benefits are being reassigned, or a reassignment is being terminated. If the organization/group's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block. The organization/group's name as reported to the IRS must be the same as reported on the organization/group's CMS-855B when it enrolled.

Change Add Terminate **Effective Date (mm/dd/yyyy):** _____

Organization/Group Legal Business Name (as Reported to the Internal Revenue Service)

Tax Identification Number (TIN)	Medicare Identification Number (PTAN) (if issued)	National Provider Identifier (NPI)
_____	_____	_____

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Section 15: Certification Statement and Signature

A. Certification Statement

- Medicare requirements providers must meet and maintain in order to bill Medicare
- By signing the form, the individual provider agrees to adhere to the requirements listed

SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE

As an individual practitioner, you are the only person who can sign this application. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing this Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry into or have your billing privileges revoked from the Medicare program if any requirements are not met.

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or organization/group unless the individual practitioner who provided the services specifically authorizes another individual or organization/group to receive said payments in accordance with 42 C.F.R. section 424.73 and 42 C.F.R. section 424.80. By signing this Certification Statement, you are authorizing the organization/group or individual identified in Section 4F to receive Medicare payments on your behalf. The signature(s) below authorize the reassignment of benefits, or the termination of a reassignment of benefits, between the individual practitioner shown in Section 2A and the organization/group or individual shown in Section 4F. The employment of, or contract between, the individual practitioner and organization/group or individual must be in compliance with CMS regulations and applicable Medicare program safeguard standards described in 42 C.F.R. section 424.80. These signatures also serve as an attestation and acknowledgment to the compliance with all laws and regulations pertaining to the reassignment of Medicare benefits. **NOTE:** this language only applies if the application is submitted to establish, change or terminate a reassignment of benefits.

A. CERTIFICATION STATEMENT

You **MUST** sign and date the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

Under the penalty of perjury, I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct or complete, I agree to notify my designated Medicare Administrative Contractor of this fact in accordance with the time frames established in 42 C.F.R. section 424.516.
2. I authorize the Medicare Administrative Contractor to verify the information contained herein. I agree to notify the Medicare Administrative Contractor of any change in practice location, final adverse legal action, or any other changes to the information in this form in accordance with the timeframes established in 42 C.F.R. section 424.516. I understand that any change to my status as an individual practitioner may require the submission of a new application. I understand that any change in the business structure of my private practice may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any alteration of any text on this application, may be punishable by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 4A of this application. The Medicare laws, regulations, and program instructions are available through the Medicare Administrative Contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b) (section 11288(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)).
5. Neither I, nor any managing employee reported in this application, is currently sanctioned, suspended, debarred or excluded by Medicare or a State Health Care Program (e.g., Medicaid program), or any other Federal program, or is otherwise prohibited from providing services to Medicare or other federal program beneficiaries.

Section 15: Certification Statement and Signature

- A. Certification Statement (continue)
- B. Signature and Date
 - Signed only by the Individual provider
- C. Delegated or Authorized Official of Individual/Organization/Group Certification Statement and Signature
 - Sign and date for reassignment of benefits

• Note

- Must be original signature in ink
- Stamped signatures are not acceptable
- Reassignment
 - Add reassignment: B and C signatures are required
 - Terminating or making a change: B **or** C signature is required

SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE (Continued)

6. I agree that any existing or future overpayment made to me, or to my business as reported in section 4A, by the Medicare program, may be recouped by Medicare through the withholding of future payments.

7. I understand that the Medicare identification number (PTAN) issued to me can only be used by me or by a Medicare enrolled provider or supplier to whom I have reassigned my benefits under current Medicare regulations when billing for services rendered by me.

8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges and the signature below is my signature.

B. SIGNATURE AND DATE

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Practitioner Signature (First, Middle, Last Name, Jr., Sr., M.D., etc.)			Date Signed (mm/dd/yyyy)

In order to process this application it MUST be signed and dated.

C. DELEGATED OR AUTHORIZED OFFICIAL OF INDIVIDUAL/Organization/Group Certification Statement and Signature

Reassignment

Only complete this section if you are a Delegated/Authorized Official of an organization/group or an individual practitioner receiving reassigned benefits and are accepting a new reassignment of Medicare benefits, terminating a reassignment of Medicare benefits, or making a change in reassignment of Medicare benefit information in Section 4f, between yourself and the individual practitioner listed in Section 2A.

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me and/or the organization/group to liability under civil and criminal laws.

Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Delegated or Authorized Official's Signature (First, Middle, Last Name, Jr., Sr., M.D., etc.)			Date Signed (mm/dd/yyyy)

In order to process this application it MUST be signed and dated.

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Supporting Documentation

Key Documents

- The following key documents are required when applicable
 - CMS-460 Medicare Participating Physician or Supplier Agreement (optional)
 - CMS-588 Electronic Funds Transfer Authorization Agreement and voided check or bank letter
 - IRS document with legal business name and TIN or EIN confirmation
 - IRS form CP-575, IRS form 147c, IRS form 501(c)(3) or Disregard entity IRS form 8832
 - Final adverse legal action documentation and resolution

Process After Submission

After Submission

- Contact person on application will receive by email
 - Acknowledgement Notice
 - Add to safe sender list
 - customerservice-donotreply@cms.hhs.gov
 - NGS-PE-Communications@elevancehealth.com
 - Development requests for additional information
 - Respond within 30 days
 - Log into PECOS to make necessary corrections or upload the required documents, view and manage signatures
 - Response letter
 - Rejection for incomplete/no response to development request
 - Approval

Check Application Status

Check Provider Enrollment Application Status

- Go to [our website](#) > Resources > Tools & Calculators > [Check Provider Enrollment Application Status](#)

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Resources > Tools & Calculators

CHECK PROVIDER ENROLLMENT APPLICATION STATUS

This inquiry tool can be used to check on the status of your application.

How to Search

To perform a search please enter into a field below either a valid Case Number/Web Tracking ID (Option 1) or a valid National Provider Identifier (NPI) and last five digits of the Tax Identification Number (TIN) combination (Option 2).

Option 1	Option 2
Case Number / Web Tracking Id <input type="text"/>	NPI <input type="text"/>
	TIN (last five digits) <input type="text"/>

Contact Information and Resources

Online Account Self-Service Features

Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

(*) Red asterisk indicates a required field.

PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

New to PECOS? View our [videos](#) at the bottom of this page.

USER LOGIN

Please use your I&A (Identity & Access Management System) user ID and password to log in.

* User ID

* Password

[LOG IN](#)

[Forgot Password?](#)

[Forgot User ID?](#)

[Manage/Update User Profile](#)

[Who Should I Call? \[PDF, 155KB\]](#) - CMS Provider Enrollment Assistance Guide

BECOME A REGISTERED USER

You may register for a user account if you are: an Individual Practitioner, Authorized or Delegated Official for a Provider or Supplier Organization, or an individual who works on behalf of Providers or Suppliers.

[Register for a user account](#)

[Questions? Learn more about registering for an account](#)

Note: If you are a Medical Provider or Supplier, you must [register for an NPI](#) before enrolling with Medicare.

Helpful Links

[Application Status](#) - Self Service Kiosk to view the status of an application submitted within the last 90 days.

Important Note: CMS is using its authority under Section 1135 of the Social Security Act to waive the application fee for any applications submitted on or after March 1, 2020 in response to COVID-19. Please do not submit an application fee with your application. For more information on provider enrollment flexibilities related to COVID-19, please visit the [CMS website \[PDF\]](#).

[Pay Application Fee](#) - Pay your application fee online.

[View the list of Providers and Suppliers \[PDF, 94KB\]](#) who are required to pay an application fee.



[E-Sign your PECOS application](#) - Access the PECOS E-Signature website using your identifying information, email address, and unique PIN to electronically sign your application.

Contact Information

For Assistance With	Contact	Contact Information
<ul style="list-style-type: none">• Changing an NPPES password• Establishing a new user ID and password for NPPES• Questions related to the NPI application	NPI Enumerator	Phone: 800-465-3203 TTY: 800-692-2326 Email: customerservice@npienumerator.com
<ul style="list-style-type: none">• Errors encountered while accessing or entering information in PECOS• Forgotten PECOS user IDs and passwords	EUS Help Desk	Phone: 866-484-8049 TTY: 866-523-4759 Email: EUSSupport@cgi.com Live Chat: https://eus.custhelp.com/

NGS Website

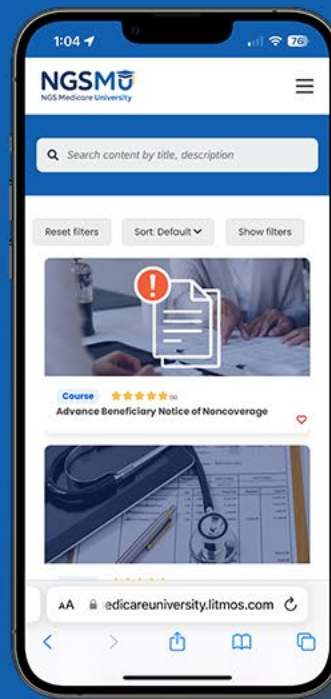
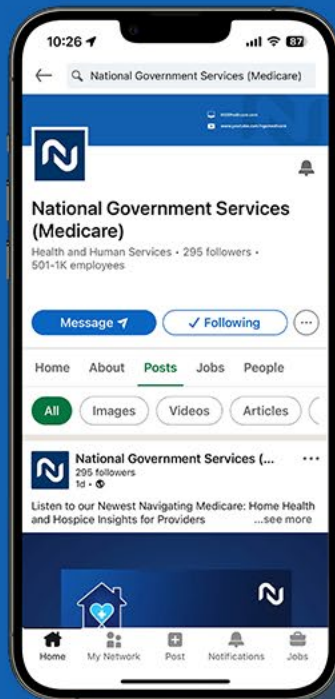
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Mailing Addresses

For ADRs, claims, EDI, FOIA, medical policy,
enrollment, or other inquiries.

Provider Enrollment



Connect with us on social media



[YouTube Channel](#)
Educational Videos



[Medicare University](#)
Self-paced online learning



[LinkedIn](#)
Educational Content

Find us online



www.NGS Medicare.com

Online resources, event calendar, LCD/NCD, and tools



[IVR System](#)

The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries



[NGSConnex](#)

Web portal for claim information



[Sign up for Email Updates](#)

Subscribe for Email updates at the top of any NGS Medicare.com webpage to stay informed of news

Questions?

Thank you!